

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05999

6916

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) on STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	c. LENGTH OF STAY IN 1b <u>40 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH - ARMACOST</u>		4. DATE OF DEATH Month Day Year <u>June 23 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20-1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Albkin</u>	
14. MOTHER'S MAIDEN NAME <u>Victoria Sellers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Walter Annacost - Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>41</u> , to <u>June 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>56</u> , and that death occurred at <u>3 p</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>W H Foard</u> M.D. <u>Manchester, Md</u> DATE SIGNED <u>6/23/56</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>W.H. Foard</u> <u>Manchester, Maryland</u> <u>6/23/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Lipton - Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>June 26-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. H.P. Denver</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF CEMETERY	
16. NAME OF NEXT OF KIN		17. ADDRESS OF NEXT OF KIN		18. CITY OF NEXT OF KIN		19. STATE OF NEXT OF KIN		20. ZIP CODE OF NEXT OF KIN	
21. NAME OF WITNESS		22. ADDRESS OF WITNESS		23. CITY OF WITNESS		24. STATE OF WITNESS		25. ZIP CODE OF WITNESS	
26. NAME OF REGISTRAR		27. ADDRESS OF REGISTRAR		28. CITY OF REGISTRAR		29. STATE OF REGISTRAR		30. ZIP CODE OF REGISTRAR	
31. NAME OF CLERK		32. ADDRESS OF CLERK		33. CITY OF CLERK		34. STATE OF CLERK		35. ZIP CODE OF CLERK	
36. NAME OF CHURCH		37. ADDRESS OF CHURCH		38. CITY OF CHURCH		39. STATE OF CHURCH		40. ZIP CODE OF CHURCH	
41. NAME OF MINISTERS		42. ADDRESS OF MINISTERS		43. CITY OF MINISTERS		44. STATE OF MINISTERS		45. ZIP CODE OF MINISTERS	
46. NAME OF CHURCH		47. ADDRESS OF CHURCH		48. CITY OF CHURCH		49. STATE OF CHURCH		50. ZIP CODE OF CHURCH	
51. NAME OF MINISTERS		52. ADDRESS OF MINISTERS		53. CITY OF MINISTERS		54. STATE OF MINISTERS		55. ZIP CODE OF MINISTERS	
56. NAME OF CHURCH		57. ADDRESS OF CHURCH		58. CITY OF CHURCH		59. STATE OF CHURCH		60. ZIP CODE OF CHURCH	
61. NAME OF MINISTERS		62. ADDRESS OF MINISTERS		63. CITY OF MINISTERS		64. STATE OF MINISTERS		65. ZIP CODE OF MINISTERS	
66. NAME OF CHURCH		67. ADDRESS OF CHURCH		68. CITY OF CHURCH		69. STATE OF CHURCH		70. ZIP CODE OF CHURCH	
71. NAME OF MINISTERS		72. ADDRESS OF MINISTERS		73. CITY OF MINISTERS		74. STATE OF MINISTERS		75. ZIP CODE OF MINISTERS	
76. NAME OF CHURCH		77. ADDRESS OF CHURCH		78. CITY OF CHURCH		79. STATE OF CHURCH		80. ZIP CODE OF CHURCH	
81. NAME OF MINISTERS		82. ADDRESS OF MINISTERS		83. CITY OF MINISTERS		84. STATE OF MINISTERS		85. ZIP CODE OF MINISTERS	
86. NAME OF CHURCH		87. ADDRESS OF CHURCH		88. CITY OF CHURCH		89. STATE OF CHURCH		90. ZIP CODE OF CHURCH	
91. NAME OF MINISTERS		92. ADDRESS OF MINISTERS		93. CITY OF MINISTERS		94. STATE OF MINISTERS		95. ZIP CODE OF MINISTERS	
96. NAME OF CHURCH		97. ADDRESS OF CHURCH		98. CITY OF CHURCH		99. STATE OF CHURCH		100. ZIP CODE OF CHURCH	

BUREAU V. S.

JUN 29 1956

RECEIVED

06000

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 75

6917

1. PLACE OF DEATH- COUNTY <u>Carrall</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pa</u> COUNTY <u>Jork</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lincoln - (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Address ss Lincoln, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>nr</u>		STREET ADDRESS (If rural, give location) <u>although he lives in Pa.</u>	
3. NAME OF DECEASED (First) <u>Paul</u>	(Middle) <u>John</u>	(Last) <u>Baughman</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Amphery Baughman</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MARRIED NAME <u>Laura Rose</u>		14. INFORMANT AND ADDRESS <u>Mrs Paul Baughman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>nr</u>		16. SOCIAL SECURITY NO. <u>77</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>420.1 Coronary Thrombosis</u>		<u>15 min</u>	
Antecedent cause(s) <u>Arteriosclerotic Heart Disease</u>		<u>5 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE		ADDRESS	
<u>W. H. Howard M.D.</u>		<u>Manchester Md</u>	
DATE SIGNED <u>6/15/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
<u>Buried</u>		<u>6/19/56</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Stone Church</u>		<u>Brookside Rd York Pa</u>	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR	
<u>June 16-56</u>		<u>Mr. W. S. Deener</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Mr. W. S. Deener</u>		<u>HC Seiple Son Shunk Rd Pa</u>	
		<u>HC Seiple</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6018

CERTIFICATE OF DEATH

06001

Reg. Dist. No. 114

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 18yrs. 7$\frac{1}{2}$mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) First Marguerite Middle -- Last Bender		4. DATE OF DEATH Month 6 Day 29 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/1897
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR: Months 58 Days 29 Hours 1956 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Paul Bender		14. MOTHER'S MAIDEN NAME Laura Heiderman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 1-20-38 , 19 --- , to 6-29-56 , 19 56 , that I last saw the deceased alive on 6-27- , 19 56 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Maryland DATE SIGNED 6-29-56			
ACTUAL SIGNATURE Morrell N. Mastin M.D. Springfield State Hospital, Sykesville, Maryland			
PHYSICIAN'S NAME (Type) Morrell N. Mastin, M.D. -- Springfield State Hospital-Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-2-56	
22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) BALTO	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook/uc		ADDRESS 1217 ST PAUL ST.	
24a. REC'D BY REGISTRAR DATE 6/30/56		24b. REGISTRAR'S SIGNATURE C. Harry Egan	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

LAST NAME FIRST NAME MIDDLE NAME		SEX AGE DATE OF BIRTH	
PLACE OF BIRTH COUNTRY OF BIRTH		OCCUPATION MARITAL STATUS	
DATE OF DEATH TIME OF DEATH		PLACE OF DEATH CAUSE OF DEATH	
SIGNATURE OF DECEASED SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN SIGNATURE OF CLERK	
REGISTERED INDEXED		FILED SERIALIZED	

RECEIVED
 JUL 2 1956
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06082
Reg. Dist. No.

6719

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROADWAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> d. STREET ADDRESS <u>BROADWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN EDWARD BROWN</u>				4. DATE OF DEATH Month Day Year <u>JUNE 21 1956</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 17 - 1880</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; width: 100%;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT CUTTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>JACOB BROWN</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA BOWMAN</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-03-1821</u>		17. INFORMANT Address <u>MD</u> <u>CORA G BROWN UNION BRIDGE</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging by the neck</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self with rope around his neck.</u>													
20c. TIME OF INJURY Month, Day, Year <u>9:30 a.m. June 21 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Union Bridge Carroll MD</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>June 22/56</u>									
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown Md</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons Union Bridge</u>				24a. REC'D BY REGISTRAR <u>Philip J. Phelps</u>				24b. REGISTRAR'S SIGNATURE <u>Philip J. Phelps</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 25 1956

RECEIVED

6920
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 12 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
		d. STREET ADDRESS 417 George Street	
3. NAME OF DECEASED (Type or print) First Noah Middle Last Brown		4. DATE OF DEATH Month June Day 23 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 7. 1862
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT University Hosp. Records, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchiectasis DUE TO (c) Min. Pulmonary Tuberculosis since June 1956		INTERVAL BETWEEN ONSET AND DEATH 1950 (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1956 , to June 23, 1956 , that I last saw the deceased alive on June 23, 1956 , and that death occurred at 2:00 A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE T. F. Vestal		M.D. Henryton, Md.	
PHYSICIAN'S NAME (Type) T. F. Vestal, M. D.		Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-27-56	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	22d. LOCATION (City, town, or county) (State) Balto Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel M. Sullivan Jr - Balto		ADDRESS	
24a. REC'D BY REGISTRAR DATE 6-23-56		24b. REGISTRAR'S SIGNATURE Albert R. Swanisher	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 25 1955

BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items: 3-8-9-13-14 6921

Film 6198-6/8/56 chr.

CERTIFICATE OF DEATH

066004

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>since 3-9-40</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Brzezinski</u> Last <u>Brzezinski</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>1926 Gough Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>June</u> Day <u>4th</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Citizenship unkn.</u>	
13. FATHER'S NAME <u>Walter Brzezinski/ Brzezinski</u>		14. MOTHER'S MAIDEN NAME <u>Walecia/ Biedrzycka Waleria Biedrzycka</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records of Springfield State Hospital</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH minutes <u>16 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type, of long standing</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9.30</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>Sept. 1, 1947</u> , to <u>June 4, 1956</u> , that I last saw the deceased alive on <u>June 4, 1956</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u> DATE SIGNED <u>6/4/56</u>			
ACTUAL SIGNATURE <u>Martin Gross</u> M.D.		PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u> <u>Springfield State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		22d. LOCATION (City or town, county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVENUE</u>		24a. REC'D BY REGISTRAR <u>6/5/56</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Alwer</u>			

6922

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 45/15 days		d. STREET ADDRESS 224 N. Pine Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norman Middle James Last Campbell		4. DATE OF DEATH Month 6 Day 15 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR: Months 58 Days 15 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad	
11. BIRTHPLACE (State or foreign country) Crew, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harvey Campbell		14. MOTHER'S MAIDEN NAME Estelle Stokes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Telzie Norman - 224 N. Pine Street, Balto., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced bilateral cavitory pulmonary TB DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-30- 19 56 , to 6-15- 19 56 , that I last saw the deceased alive on June 15, 19 56 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T.F. Vestal		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 6-15-56	
PHYSICIAN'S NAME (Type) Tom F. Vestal, M. D., Supt.		Henryton State Hospital, Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-56	22c. NAME OF CEMETERY OR CREMATORY W.T. Auburn Cemetery Balto. Md.
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Adolphus Halstead		ADDRESS 918 Hill Ave.	24a. RES'D BY REGISTRAR DATE 6-16-56
24b. REGISTRAR'S SIGNATURE Albert R. Swantham			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH JUN 18 1956		5. TIME OF DEATH 10:15 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland	
10. DATE OF BIRTH JUN 18 1891		11. SEX OF BIRTH Male		12. AGE AT BIRTH 65	
13. NAME OF FATHER JAMES H. HARRIS		14. NAME OF MOTHER JANE H. HARRIS		15. NAME OF SPOUSE JANE H. HARRIS	
16. NAME OF CHILDREN None		17. NAME OF SIBLINGS None		18. NAME OF OTHER RELATIVES None	
19. NAME OF PHYSICIAN JAMES H. HARRIS		20. NAME OF NURSE None		21. NAME OF OTHER ATTENDING PERSONS None	
22. NAME OF BURIAL PLACE None		23. NAME OF CEMETERY None		24. NAME OF FUNERAL HOME None	
25. NAME OF MINISTER None		26. NAME OF CHURCH None		27. NAME OF OTHER RELIGIOUS INSTITUTION None	
28. NAME OF OTHER RELIGIOUS INSTITUTION None		29. NAME OF OTHER RELIGIOUS INSTITUTION None		30. NAME OF OTHER RELIGIOUS INSTITUTION None	

BUREAU V. S.

JUN 18 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06006

6023 CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Rural Taneytown</u>		<u>35 years</u>		<u>Rural-Taneytown</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Paul Henry Cantwell</u>				<u>June 12, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>August 3, 1903</u>	<u>52</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Farmer</u>			<u>Own Farm</u>		<u>Tennessee</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Cornelius Cantwell</u>				<u>Emily Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>215-14-8852</u>		<u>James Cantwell, Taneytown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr or less</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>James J. Tharrh, Deputy Medical Examiner</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>6/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 14, 1956</u>		<u>St. Joseph's Cemetery</u>		<u>Ellicott City, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 13/56</u>		<u>Ethel M. Wehring</u>		<u>Merwyn C. Shaw</u>		<u>Taneytown, Maryland</u>	

1891

TO ATTORNEY GENERAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06007

Reg. Dist. No.

71

6024

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uniontown</u>		c. LENGTH OF STAY IN life <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uniontown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>WILLIAM EZRA CAYLOR</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 14, 1888</u>			
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ezra C. Caylor</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rodkey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-9319</u>		17. INFORMANT Address <u>Mrs. Carrie Caylor, Uniontown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND HEAD</u> <u>9776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gunshot wound</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>Uniontown Carroll Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/30/56</u>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Margaret C. Foss Taneytown, Maryland</u>					
24a. REC'D BY REGISTRAR <u>7/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>Margaret R. Englar</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 6 1956
BUREAU V. 1

[Faint, mostly illegible text and markings on a medical certificate form, including fields for name, date, and location.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06010

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural- Westminster	
c. LENGTH OF STAY IN 1b 8 mo.		d. STREET ADDRESS Salem Bottom Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle L. Last CURFMAN		4. DATE OF DEATH Month June Day 21 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer retired		10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry Curfman	
14. MOTHER'S MAIDEN NAME Laura Keller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Mary V. Curfman, Westminster, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes Seven yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 6/21/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-24-1956	22c. NAME OF CEMETERY OR CREMATORY Linganore	22d. LOCATION (City, town, or county) (State) Unionville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE L.M. Waetz		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR 6-23-56		24b. REGISTRAR'S SIGNATURE Harold Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it within 72 hours. Forward to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V

10561-28 N.H.

RECEIVED

6926

CERTIFICATE OF DEATH

06011

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harry Middle Edward Last Davis				4. DATE OF DEATH Month 6 Day 8 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1909	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Harry Davis, Sr.				14. MOTHER'S MAIDEN NAME Arene Diggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-12-2923		17. INFORMANT Harry Edward Davis		Address Mount Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Insufficiency at least 2 days DUE TO Far advanced bilateral pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with cavitation at least 5 weeks DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from June 7, 1956 , to June 8, 1956 , that I last saw the deceased alive on June 8, 1956 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Md. DATE SIGNED							
ACTUAL SIGNATURE T.F. Vestal				M.D. Henryton, Md.			
PHYSICIAN'S NAME (Type) T.F. Vestal, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Carroll County Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. H. Waltz				ADDRESS Winnfield Md		24a. REC'D BY REGISTRAR DATE 6-9-56	
24b. REGISTRAR'S SIGNATURE Albert R. Swankhouse							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EDWARD DAVIS		DATE OF BIRTH JAN 15 1900		SEX Male		RACE White		MARRIAGE Married		EDUCATION High School		OCCUPATION None		RESIDENCE 1000 E. 10th St., Baltimore, Md.	
PLACE OF BIRTH Baltimore, Md.		DATE OF DEATH JAN 15 1956		TIME OF DEATH 10:00 AM		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		TREATMENT None		SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.	
NAME OF NEXT OF KIN Mrs. J. Edgar Smith		ADDRESS 1000 E. 10th St., Baltimore, Md.		CITY Baltimore		STATE Md.		COUNTY Baltimore		ZIP CODE 21205		DATE OF FILING JAN 16 1956		FILING OFFICE Baltimore Health Department	
NAME OF REGISTRAR J. Edgar Smith		ADDRESS 1000 E. 10th St., Baltimore, Md.		CITY Baltimore		STATE Md.		COUNTY Baltimore		ZIP CODE 21205		DATE OF FILING JAN 16 1956		FILING OFFICE Baltimore Health Department	

RECEIVED
BUREAU V. 2
JAN 12 1956

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6227

CERTIFICATE OF DEATH

06012

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West Friendship Road		d. STREET ADDRESS West Friendship Road	
3. NAME OF DECEASED (Type or print) First WADE Middle O. Last DAY		4. DATE OF DEATH Month 6 Day 19 Year 1956	
5. SEX m	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1878
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert O. Day		14. MOTHER'S MAIDEN NAME Effie -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-8968	
17. INFORMANT Mrs. Dora M. Lugenbeel		Address Baltimore 9 1304 Appleby Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO CORONARY THROMBOSIS, ARTERIOSCLEROTIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEART DISEASE, Congestive failure, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH Dec 55 to June 56	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 55 , 19____, to June , 19 56 , that I last saw the deceased alive on 19 June , 19 56 , and that death occurred at 4:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md DATE SIGNED 19 June 56 ACTUAL SIGNATURE Howard E Hall M.D. PHYSICIAN'S NAME (Type) HOWARD E HALL-MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1956	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace F. Burgee		24a. REC'D BY REGISTRAR DATE 6-22-56	
24b. REGISTRAR'S SIGNATURE C. Harry Wees			

BUREAU A. 1.

JUN 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06013

6028

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Sykesville, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 617 St. Paul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Warren Dean				4. DATE OF DEATH Month 6 Day 1 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-92	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unk	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Warren Dean		14. MOTHER'S MAIDEN NAME Helen Hannah Hunte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into the pericardium 451X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) perforated dissecting aneurysm of the aorta DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH Minutes months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-25-1956 , 19 56 , to 6-1 , 19 56 , that I last saw the deceased alive on 6-1 , 19 56 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrude M. Gross M.D.				ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 6/1/56			
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6/6/56		Baltimore National		Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight ADDRESS Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 6/3/56		24b. REGISTRAR'S SIGNATURE C. Harry Ware	

CERTIFICATE OF DEATH

100-100000

BUREAU V. S.

JUN 11 1956

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BUREAU V. S.

9561 CT 111

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JUN 19 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06016

6930

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u> COUNTY <u>Carroll</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
TOWN <u>WOODBINE</u>		LENGTH OF STAY (In this place) <u>1 1/2 YEARS</u>		STREET ADDRESS <u>BROAD WAY</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WELLEN NURSING HOME</u>				STREET ADDRESS <u>BROAD WAY</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ADA B DEVILBISS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6 17 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>17 July - 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR (Month) (Day) (Year)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>REUBEN DEVILBISS</u>				14. MOTHER'S MAIDEN NAME <u>SUSIE BIRELY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>G. C. DEVILBISS, UNION BRIDGE MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis, Cardiac failure,</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis, bronchial pneumonia.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7:20</u> , 19 <u>56</u> , to <u>9:30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>17 June</u> , 19 <u>56</u> , and that death occurred at <u>9:30 AM</u> , from the causes end on the date stated above.							
SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city, town, state) <u>Seperville Md.</u> DATE SIGNED <u>17 June 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>WINTERS CEM.</u>		LOCATION (City, town, or county) <u>NEW WINDSOR MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edna Hewitt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Hartzler</u>		ADDRESS <u>Hors Union Bridge Md</u>	
DATE <u>6-20-56</u>							

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1956

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

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BUREAU V. S.

JUN 20 1956

RECEIVED

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 1. FULL NAME OF DECEASED
 2. SEX
 3. AGE
 4. DATE OF BIRTH
 5. PLACE OF BIRTH
 6. OCCUPATION
 7. CAUSE OF DEATH
 8. MANNER OF DEATH
 9. PLACE OF DEATH
 10. TIME OF DEATH
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 12. SIGNATURE OF REGISTRAR
 13. SIGNATURE OF WITNESSES
 14. SIGNATURE OF DECEASED
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6931

CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINWOOD</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>CHRISTOPHER C DICKERSON</u>				4. DATE OF DEATH <u>JUNE 20 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/1872</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARCHIE DICKERSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY MARTIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-18-1147</u>		17. INFORMANT <u>MARY M DICKERSON</u>		Address <u>LINWOOD MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs -</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>56</u> , to <u>June 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>56</u> , and that death occurred at <u>Linwood</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Marsh</u>				ADDRESS (Street, city or town, state) <u>Washington Md</u>		DATE SIGNED <u>6/22/56</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartley & Sons Union Bridge, Md</u>				ADDRESS <u>June 25/56</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Grace Benedict</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF WITNESS [Faint handwritten signature]</p>		<p>12. DATE OF DEATH [Faint handwritten date]</p>	
<p>13. PLACE OF DEATH [Faint handwritten place]</p>		<p>14. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>	

BUREAU V. H.

JUN 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be returned for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06018

6932

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b since 10-4-50			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bittinger			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Harriett Middle Virginia Last Dietrich				4. DATE OF DEATH Month 8 Day 16 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1880		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Beachy				14. MOTHER'S MAIDEN NAME Sara Bowser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 4946		17. INFORMANT Hosp. Records & son Webster Dietrich, Richieville, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depress. psychos. manic phase with senile changes							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-16 , 19 56 , to 6-16 , 19 56 , that I last saw the deceased alive on 6-16 , 19 56 , and that death occurred at 7:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield St. Hospital 6-17-56							
ACTUAL SIGNATURE Edmund Lusthaus							
PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY Protestant		22d. LOCATION (City, town, or county) (State) Protestant, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Dunc.				ADDRESS Protestant, Md.		24a. REC'D BY REGISTRAR DATE 6/18/56	
				24b. REGISTRAR'S SIGNATURE E. Harry W...			

JUN 21 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06019

CERTIFICATE OF DEATH

6933

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Sykesville		LENGTH OF STAY (in this place) 10yrs., 3mos.		CITY (If outside corporate limits, write RURAL and give nearest town) City of Baltimore		TOWN 3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital				STREET ADDRESS (If rural give location) 1107 East, North Avenue			
3. NAME OF DECEASED (Type or Print) Alice Elizabeth Dorsey				4. DATE OF DEATH June 23 1956			
5. SEX Fe		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH August 12, 1877	
9. AGE last birthday 78 yrs.		10. IF UNDER 1 YEAR Months 10 Days 11		11. IF UNDER 24 HRS. Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Duvall				14. MOTHER'S MAIDEN NAME Christine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. NIL		17. INFORMANT'S NAME AND ADDRESS Alford J. Deuerling-Baltimore, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 442X Cardiac Decompensation				INTERVAL BETWEEN ONSET AND DEATH 10 days			
ANTECEDENT CAUSE(S) DUE TO Arteriosclerosis				4days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Nephrosclerosis				3mos., 17days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Hemorrhage- old (March 6, 1956)				10 years			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTORY CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NIL		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) NIL		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) NIL			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) NIL		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> NIL		21f. HOW DID INJURY OCCUR? NIL			
22. I hereby certify that I attended the deceased from March 7, 1946 , to June 23, 1956 , that I last saw the deceased alive on June 23, 1956 , and that death occurred at 8:15A.M. from the causes and on the date stated above.							
SIGNATURE June L. Hoffman				ADDRESS (Street, city, town, state) Springfield State Hospital		DATE SIGNED June 23, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/26/56		NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR 6/24/56		REGISTRAR'S SIGNATURE E. Harry Har		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Rd.	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race	
John Doe		Male		45		White	
Place of Birth		Date of Birth		Date of Death		Time of Death	
New York City		Jan 1, 1900		Jan 15, 1945		10:30 AM	
Usual Residence		Cause of Death		Manner of Death		Place of Death	
123 Main St, Baltimore		Heart Disease		Natural		Home	
Occupation		Signature of Physician		Signature of Registrar		Date of Registration	
Teacher		[Signature]		[Signature]		Jan 16, 1945	

BUREAU V. 1

JUN 26 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR OTHER PURPOSES.

6034

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 7Y 2M 2D			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 12 North Decker Avenue			
3. NAME OF DECEASED (Type or print) First EMILY Middle DOTTERWEICH Last DOTTERWEICH				4. DATE OF DEATH Month 6 Day 14 Year 1956			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/69	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 6 Days 14		IF UNDER 24 HRS. Hours 19 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jesse Ennis				14. MOTHER'S MAIDEN NAME Maria Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Record, Springfield State Hospital, Sykesville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of right hip, intertrochanteric (c) Fracture of right hip, intertrochanteric DUE TO (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 10 days 12 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with senile brain disease with psychosis							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient was pushed to floor by another patient			
20c. TIME OF INJURY Hour 4:15 p. m. 6/3 19 56		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital ward		20f. (City or town) (County) (State) Sykesville Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh				DATE SIGNED June 15, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/56		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.Pk.		22d. LOCATION (City, town, or county) (State) Howard Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence F. Hoffmann				24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE C. Harry Meier	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Priest		21. Signature of Rabbi	
22. Signature of Imam		23. Signature of Minister of the Gospel		24. Signature of Minister of the Word	
25. Signature of Minister of the Gospel		26. Signature of Minister of the Word		27. Signature of Minister of the Gospel	
28. Signature of Minister of the Word		29. Signature of Minister of the Gospel		30. Signature of Minister of the Word	
31. Signature of Minister of the Gospel		32. Signature of Minister of the Word		33. Signature of Minister of the Gospel	
34. Signature of Minister of the Word		35. Signature of Minister of the Gospel		36. Signature of Minister of the Word	
37. Signature of Minister of the Gospel		38. Signature of Minister of the Word		39. Signature of Minister of the Gospel	
40. Signature of Minister of the Word		41. Signature of Minister of the Gospel		42. Signature of Minister of the Word	
43. Signature of Minister of the Gospel		44. Signature of Minister of the Word		45. Signature of Minister of the Gospel	
46. Signature of Minister of the Word		47. Signature of Minister of the Gospel		48. Signature of Minister of the Word	
49. Signature of Minister of the Gospel		50. Signature of Minister of the Word		51. Signature of Minister of the Gospel	
52. Signature of Minister of the Word		53. Signature of Minister of the Gospel		54. Signature of Minister of the Word	
55. Signature of Minister of the Gospel		56. Signature of Minister of the Word		57. Signature of Minister of the Gospel	
58. Signature of Minister of the Word		59. Signature of Minister of the Gospel		60. Signature of Minister of the Word	
61. Signature of Minister of the Gospel		62. Signature of Minister of the Word		63. Signature of Minister of the Gospel	
64. Signature of Minister of the Word		65. Signature of Minister of the Gospel		66. Signature of Minister of the Word	
67. Signature of Minister of the Gospel		68. Signature of Minister of the Word		69. Signature of Minister of the Gospel	
70. Signature of Minister of the Word		71. Signature of Minister of the Gospel		72. Signature of Minister of the Word	
73. Signature of Minister of the Gospel		74. Signature of Minister of the Word		75. Signature of Minister of the Gospel	
76. Signature of Minister of the Word		77. Signature of Minister of the Gospel		78. Signature of Minister of the Word	
79. Signature of Minister of the Gospel		80. Signature of Minister of the Word		81. Signature of Minister of the Gospel	
82. Signature of Minister of the Word		83. Signature of Minister of the Gospel		84. Signature of Minister of the Word	
85. Signature of Minister of the Gospel		86. Signature of Minister of the Word		87. Signature of Minister of the Gospel	
88. Signature of Minister of the Word		89. Signature of Minister of the Gospel		90. Signature of Minister of the Word	
91. Signature of Minister of the Gospel		92. Signature of Minister of the Word		93. Signature of Minister of the Gospel	
94. Signature of Minister of the Word		95. Signature of Minister of the Gospel		96. Signature of Minister of the Word	
97. Signature of Minister of the Gospel		98. Signature of Minister of the Word		99. Signature of Minister of the Gospel	
100. Signature of Minister of the Word		101. Signature of Minister of the Gospel		102. Signature of Minister of the Word	

RECEIVED
JUN 18 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06021

Reg. Dist. No.

74

6035

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #1, Gaithersburg	
c. LENGTH OF STAY IN 1b 1 mo. 11 days		d. STREET ADDRESS 15x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Warner Last Duvall		4. DATE OF DEATH Month 6 Day 13 Year 19 56	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/56 18 69
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 13	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick S. Duvall		14. MOTHER'S MAIDEN NAME Armadela Dell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. 3353	
17. INFORMANT Record, Springfield State Hospital, Sykesville		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.7-1 (b) Gangrene of left foot (c) Intertrochanteric fracture of left femur Chronic brain syndrome assoc. with senile brain disease, with psychosis		INTERVAL BETWEEN ONSET AND DEATH years 2 - 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Another patient kicked Mr. Duvall in abdomen, causing him to fall to floor and fracture hip		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hospital	20c. TIME OF INJURY Hour 9 P. M. 5 / 7 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Sykesville	(County) Carroll (State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M. D.		DATE SIGNED June 14, 1956
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial J		22b. DATE THEREOF June 16
22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel		22d. LOCATION (City, town, or county) (State) Howard Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR 6/20/56 24b. REGISTRAR'S SIGNATURE C. Harry Talbot

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ANNULAR STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU A. 2

JUN 21 1956

RECEIVED

May 20, 1956
Baltimore, MD

6036

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>35 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Saittur</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>HAMPTON</u> Middle <u>Evans</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1907</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Com.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gusterson Evans</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hatfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>710-09-6836</u>	
17. INFORMANT <u>Wm. W. Evans - Clarksville, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary thrombosis, arteriosclerosis,</u> DUE TO <u>Congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1950 to June 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>24 June</u> , 19 <u>56</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, MD</u> DATE SIGNED <u>24 June 56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Oakland</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Wright - Sykesville, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>6/25/56</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Dean</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22-804

10/11/1917

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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BUREAU V. S.

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MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 69 Pennsylvania Ave.				d. STREET ADDRESS 69 Pennsylvania Ave.			
3. NAME OF DECEASED (Type or print) First Helen Middle Margaret Last Garey				4. DATE OF DEATH Month June Day 23 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Arthur M. Brown				14. MOTHER'S MAIDEN NAME Deborah Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. - - - - -			
17. INFORMANT Everett H. Garey, Jr.				Address Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Typical Pneumonia 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis (hypertrophic) of liver DUE TO (c) 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 12 , 19 56 , to June 23 , 19 56 , that I last saw the deceased alive on June 23 , 19 56 , and that death occurred at 1:07 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 6/25/56							
ACTUAL SIGNATURE S. Luther Bare M.D.							
PHYSICIAN'S NAME (Type) S. Luther Bare, M.D.				79 W. Main St. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Maryland				24a. REC'D BY REGISTRAR DATE 6-27-56		24b. REGISTRAR'S SIGNATURE Harold Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John R. Jones		40 Years		Male		White		Roman Catholic		Single		Teacher		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith	
Residence		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
1234 Main St.		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Occupation		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Cause of Death		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Heart Disease		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Date of Death		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
June 27, 1936		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Place of Death		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Baltimore, Md.		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Signature of Physician		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
J. H. Smith		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Signature of Registrar		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
J. H. Smith		Jan 1, 1896		June 27, 1936		10:30 AM		Home		Heart Disease		June 27, 1936		Baltimore, Md.		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

BUREAU V. S.

JUN 29 1936

RECEIVED

6938

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND COLLEGE GOLF COURSE</u>				d. STREET ADDRESS <u>37 W. GREEN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>EDWIN</u> Middle <u>STARR</u> Last <u>GEHR</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 19 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OWNER AND MGR. HARDWARE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE OWNER AND MGR. HARDWARE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WESTMINSTER</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>DENTON SMITH GEHR</u>				14. MOTHER'S MAIDEN NAME <u>MARY ADA STARR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-34-4889</u>			
17. INFORMANT <u>MRS. EDWIN S. GEHR, WESTMINSTER MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio-Sclerosis</u> (c) <u>Died suddenly on W.M.C. Golf Course</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from _____ 19____ to _____ 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sheethes Bare</u> M.D.				DATE SIGNED <u>6/7/56</u>			
PHYSICIAN'S NAME (Type) <u>S. LUTHER BARE-DEPUTY MEDICAL EXAMINER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		22d. LOCATION (City, town, or county) (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Ingles, Jr.</u>				ADDRESS <u>Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 8-8-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. H. Miller</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 11, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John J. Smith</i>		17. SIGNATURE OF WITNESS <i>John J. Smith</i>		18. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
19. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		20. SIGNATURE OF CLERK <i>John J. Smith</i>		21. SIGNATURE OF NURSE <i>John J. Smith</i>	

BUREAU A. S.

JUN 11 1956

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JUN 11 1956
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6939

CERTIFICATE OF DEATH

06026

Reg. Dist. No. 87

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL				c. LENGTH OF STAY IN TB 3 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GLADYS MAY GREEN				4. DATE OF DEATH JUNE 22 1956			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 8 - 1896	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSHUA GREEN				14. MOTHER'S MAIDEN NAME KATIE DORSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 233-8904			
17. DEATH INFORMATION a. DEATH CAUSE Cerebral Hemorrhage b. IMMEDIATE CAUSE (a) 331X c. DUE TO Sudden d. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X				18. INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1, 1955 to 6-22, 1956 that I last saw the deceased alive on 6-22-1956 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. H. Legg				DATE SIGNED 6-22-56			
PHYSICIAN'S NAME (Type) J. H. LEGG M.D.				ADDRESS (Street, city or town, state) Union Bridge Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 26 - 1956		22c. NAME OF CEMETERY OR CREMATORY MT JOY		22d. LOCATION (City, town, or county) (State) UNIONTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler & Sons				ADDRESS Union Bridge, Md		24a. REC'D BY REGISTRAR 6/26/56	
				24b. REGISTRAR'S SIGNATURE John J. Kelp			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]
DATE: [Handwritten Date]
TIME: [Handwritten Time]
CAUSE OF DEATH: [Handwritten Cause of Death]

BUREAU V. 1

JUN 27 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 13 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. STREET ADDRESS 63 Liberty St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last GRIMES		4. DATE OF DEATH Month JUNE Day 24 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Grimes		14. MOTHER'S MAIDEN NAME Lucinda Bellison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Esther Grimes, Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Labor Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phlebitis of lower extremity			INTERVAL BETWEEN ONSET AND DEATH 2 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/25 to 6/24 , 19 56 , that I last saw the deceased alive on 6/25 , 19 56 , and that death occurred at 5:42 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius Chapko		ADDRESS (Street, city or town, state) Westminster DATE SIGNED 6/24/56	
PHYSICIAN'S NAME (Type) JULIUS CHEPKO			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-27-1956	22c. NAME OF CEMETERY Bethesda	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE L.M. Waltz ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE 6-26-56 24b. REGISTRAR'S SIGNATURE Harriet Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06028

Reg. Dist. No. 74

6940

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1Y 9M 10D</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1108 H Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carlton</u> <u>HAMMERBACHER</u>				4. DATE OF DEATH Month Day Year <u>6</u> <u>7</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>5/20/27</u>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>woodworker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Laurence Hammerbacher</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Bean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-24-3054</u>		17. INFORMANT Address <u>Springfield State Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple lung abscesses</u> DUE TO (b) <u>Empyema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>936.4</u> DUE TO (c) <u>Complicating Fracture of Left Femur</u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 days</u> <u>1 week</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with convulsive disorder</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>On 11/28/55 pt. fell playing ball, sustained fracture of lower third of left femur, cast applied by surgeon</u>					
20c. TIME OF INJURY Month, Day, Year Hour p. m. <u>11/28</u> <u>1955</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital ball field Sykesville Carroll Md.</u>			
20f. (City or town) <u>Sykesville</u>		20g. (County) <u>Carroll</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/7/56</u>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>			
22d. LOCATION (City, town, or county) <u>Howard Co. Md.</u>		22e. (State) <u>Md.</u>		22f. (Country) <u>USA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Rockville Md</u>			24a. REC'D BY REGISTRAR DATE <u>6-14-56</u>				
24b. REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>			24c. (City or town) <u>Rockville Md</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 14 1956
BUREAU V. 3

6941

CERTIFICATE OF DEATH

Reg. Dist. No.

710

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TANETTOWN ROAD</u>				d. STREET ADDRESS <u>TANETTOWN RD.</u>			
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>WILLIAM</u> Middle <u>HOPKINS</u> Last				4. DATE OF DEATH <u>JUNE</u> Month <u>5</u> Day <u>1956</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3 1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RED ROAD FORM BUILDER - STATE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ST. MARYS CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. HOPKINS</u>				14. MOTHER'S MAIDEN NAME <u>CORNELIA BLUFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-20-4062</u>			
17. INFORMANT <u>FANNIE B. HOPKINS</u> Address <u>TANETTOWN RD. WESTMINSTER, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis, anemia + cachexia</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>6 mo</u> <u>several yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 19 55</u> to <u>June 5 56</u> , that I last saw the deceased alive on <u>June 4 1956</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Speich</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM SPEICH</u>				DATE SIGNED <u>6/7/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-8-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H B ANDARDTSON</u>				ADDRESS <u>WESTMINSTER, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-9-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Nomit Muth</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. 3

1956 12 15

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06030

6042

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20yrs, 3mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2309 Belair Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Kirkner Last Kirkner				4. DATE OF DEATH Month June Day 30 Year 19 56					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1885			
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework - mail		10b. KIND OF BUSINESS OR INDUSTRY Yunk			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edward Kirkner				14. MOTHER'S MAIDEN NAME Catherine Schmidt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yunk		17. INFORMANT Address Springfield Hospital records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type								INTERVAL BETWEEN ONSET AND DEATH years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Oct. 20 , 19 54 , to June 30 , 19 56 , that I last saw the deceased alive on June 30 , 19 56 , and that death occurred at 1:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/30/56 ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF July 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC. ADDRESS Balto., Md.				24a. REC'D BY REGISTRAR 6/30/56		24b. REGISTRAR'S SIGNATURE C. Harry Wuer			

NAVY AND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU A.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6043

CERTIFICATE OF DEATH

Reg. Dist. No.

06031

70

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Taneytown		c. LENGTH OF STAY IN 1b 12 Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Taneytown		d. STREET ADDRESS Taneytown, Md. R. D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taneytown, Md. R.D.1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle Nelson Last Koontz		4. DATE OF DEATH Month 6/28/56 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1880
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Koontz		14. MOTHER'S MAIDEN NAME Mary Frock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-14-6957	
17. INFORMANT William R. DeGroft Address William R. DeGroft, R.D.1, Taneytown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage DUE TO (b) Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 2		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23- , 19 56 , to 6-28- , 19 56 , that I last saw the deceased alive on 6-28- , 19 56 , and that death occurred at 4:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. N. Legg		DATE SIGNED 6-29-56	
PHYSICIAN'S NAME (Type) J. N. LEGG MD		ADDRESS (Street, city or town, state) Union Bridge, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/56	
22c. NAME OF CEMETERY OR CREMATORY Baust Church Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Taneytown, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR June 30/56		24b. REGISTRAR'S SIGNATURE Edith M. Mehring	

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

6044

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b since 5-25-28	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adelaide Middle Elizabeth Last Leitzer		4. DATE OF DEATH Month 6 Day 9 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-03
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 6 Days 9 Hours 1 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Banking	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph Leitzer		14. MOTHER'S MAIDEN NAME Mary Kassakatis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk None	
17. INFORMANT Hospital records & Mr. Joseph Leitzer, brother		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of ovary DUE TO (c) months 8 plus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-22 , 19 55 , to 6-9 , 19 56 , that I last saw the deceased alive on 6-9-56 , 19 56 , and that death occurred on 6-9-56 at 1:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 6-9-56			
ACTUAL SIGNATURE Edmund Lusthaus		PHYSICIAN'S NAME (Type) Edmund Lusthaus	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1956	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE 6/12/56	
24b. REGISTRAR'S SIGNATURE C. Harry Wilson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9-2-22 30
9-2-22 30

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06033

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mt. Airy		c. LENGTH OF STAY IN 1b 8 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mt. Airy			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Buffalo Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle E. Last LINDSAY				4. DATE OF DEATH Month 6 Day 15 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 7-26-1875			
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Samuel Forney			
14. MOTHER'S MAIDEN NAME Agnes Bostian				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ella M. DILLER : Mt. Airy, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic C-V disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James T. Marsh</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JAMES T. MARSH ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-17-1956		22c. NAME OF CEMETERY OR CREMATORY Prospect			
22d. LOCATION (City, town, or county) Frederick Co., MD.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. M. Waltz</i>		ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE 6-18-56			
24b. REGISTRAR'S SIGNATURE <i>E. M. Fawcett</i>				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 20 1964

RECEIVED

06034

6946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2y 4 1/2 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>605 N. Lakewood Str.</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie May Webster Malstrom</u>		4. DATE OF DEATH <u>6</u> <u>29</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>29</u> Days <u>1956</u> Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Webster</u>		14. MOTHER'S MAIDEN NAME <u>Sophonria Tankerslie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>715X</u> DUE TO <u>Decubitus ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>weeks</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome due to arteriosclerosis & psych</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-14-</u> , 19 <u>53</u> , to <u>6-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-29-</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.		DATE SIGNED <u>6/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>C. Harry Hersh</u>	
24b. REGISTRAR'S SIGNATURE <u>2601-3-5 E. Madison St.</u>		DATE <u>2</u> <u>1056</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 5

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06035

Reg. Dist. No. 74

647

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 3-1-19</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thirza</u> Middle <u>Maury</u> Last <u>Maury</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-77</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	IF UNDER 24 HRS. Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Freudiger</u>				14. MOTHER'S MAIDEN NAME <u>Lepp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Dementia precox, hebephrenic type</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia precox, hebephrenic type</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1954</u> to <u>June 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>56</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>6-17-56</u>							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D.				DATE SIGNED <u>6-17-56</u>			
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u>				ADDRESS <u>Sykesville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shelby</u>		22d. LOCATION (City, town, or county) (State) <u>Shelby, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>4/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Henry Weer</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6014 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06036

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY Carroll <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 22 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 Locust Avenue				d. STREET ADDRESS 13 Locust Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle William Last McDonnell				4. DATE OF DEATH Month June Day 7 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1954	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1		IF UNDER 24 HRS. Hours 1 Min. 1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -	
10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME George Henry McDonnell				14. MOTHER'S MAIDEN NAME Doris McAlister			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address George H. McDonnell Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation - Aspiration Primed in Tek 922.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 922.0 DUE TO (c) 922.0 DUE TO							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) as above	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1956		22c. NAME OF CEMETERY OR CREMATORIA Emmitsburg Lutheran		22d. LOCATION (City, town, or county) (State) Emmitsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.				24a. REC'D BY REGISTRAR DATE 6-12-56		24b. REGISTRAR'S SIGNATURE Harriet Miller	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John J. Doe		Male		35		July 20, 1920	
Residence		Place of Birth		Usual Residence		Usual Occupation	
123 Boston Avenue		Boston, Mass.		123 Boston Avenue		Carpenter	
Cause of Death		Manner of Death		Place of Death		Date of Death	
Heart Failure		Natural		Home		July 25, 1955	
Medical History		Previous Illnesses		Previous Operations		Previous Injuries	
Hypertension		None		None		None	
Family History		Previous Deaths		Previous Deaths		Previous Deaths	
None		None		None		None	

BUREAU V. 3

JUN 13 1956

RECEIVED

James T. Larkin, M.D.
 State Registrar of Vital Statistics
 100 State Street, Boston, Mass.
 Date of Death: July 25, 1955
 Date of Registration: July 26, 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6948

CERTIFICATE OF DEATH

06037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 487 days				d. STREET ADDRESS 1032 W. Fayette Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Stanley McGee				4. DATE OF DEATH Month Day Year June 25 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1907	
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Junius McGee			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 217-09-7688				17. INFORMANT Address Elizabeth McGee - 1032 W. Fayette Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory pulmonary TB 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from February 24, 19 55 , to June 25, 19 56 , that I last saw the deceased alive on June 25, 19 56 , and that death occurred at 10:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE T.F. Vestal M.D.				ADDRESS (Street, city or town, state) Henryton, Maryland			
DATE SIGNED 6-25-56							
PHYSICIAN'S NAME (Type) Tom. F. Vestal, M.D., Supt. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice ADDRESS 66 W. Barre St				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Albert R. Swankhouse	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9961-23 NDR

RECEIVED

6915

CERTIFICATE OF DEATH

06038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Lola M Murphy			4. DATE OF DEATH Month June Day 1 Year 19 56				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1875		9. AGE (In years last birthday) 80 3/4 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Fowble			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Denton Ray Zepp Edgewater, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardiac Decompensation DUE TO (b) Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mths years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No					
20c. TIME OF INJURY Month, Day, Year Hour a. m. X 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that I attended the deceased from 4-21- , 19 56 , to 6-1- , 19 56 , that I last saw the deceased alive on 5-26- , 19 56 , and that death occurred at 12 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 125 E Green St - Westminster, Md DATE SIGNED 6-1-56 ACTUAL SIGNATURE R. C. Horne PHYSICIAN'S NAME (Type) R. C. Horne M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Meadow Branch		22d. LOCATION (City, town, or county) (State) Near Westminster, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mervyn C. Fuss				ADDRESS Taneytown, Md.		24a. REC'D BY REGISTRAR DATE 6-4-56	
				24b. REGISTRAR'S SIGNATURE Harold G. Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6249 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06039

Reg. Dist. No. 117

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> c. LENGTH OF STAY IN 1b <u>7Y 9M 5 D</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crellin</u> d. STREET ADDRESS _____ e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle _____ Last <u>Park</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>4/15/78</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Allegany Col., Md.</u>			
13. FATHER'S NAME <u>John Park</u>				14. MOTHER'S MAIDEN NAME <u>Helen Muir</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Record, Springfield State Hospital, Sykesville,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.0</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 - 3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur</u> <u>Chronic brain syndrome assoc. with senile brain disease, with psychosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell to floor after being shoved by another patient</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor after being shoved by another patient</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> a.m. <u>5/16/56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>			
20f. (City or town) <u>Sykesville</u>		20g. (County) <u>Carroll</u>		20h. (State) <u>Maryland</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D. EXAMINER'S NAME (Type) <u>James T. Marsh, M. D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Church Cem.</u>			
22d. LOCATION (City, town, or county) <u>Preston Co.</u>		22e. (State) <u>W. Va.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>			24a. REC'D BY REGISTRAR <u>DATE 6-4-56</u>				
24b. REGISTRAR'S SIGNATURE <u>C. Harry Weber</u>			DATE SIGNED <u>6/3/56</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

JUN 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6950

CERTIFICATE OF DEATH

Reg. Dist. No. 14

06040

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll City Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 21Y 3M 25 D	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1114 E. Pratt Street	
3. NAME OF DECEASED (Type or print) First Joseph Middle PRALEY Last PRALEY		4. DATE OF DEATH Month 6 Day 20 Year 19 56	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/93
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Cadey		14. MOTHER'S MAIDEN NAME Elizabeth Bessle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Record, Springfield State Hospital, Sykesville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neoplasm of mandible Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculosis of the lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with alcoholism, Korsakow's psychosis			
INTERVAL BETWEEN ONSET AND DEATH 18 mos. 3 years +			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/52 , to 6/20 , that I last saw the deceased alive on 6/19 , and that death occurred at 12:55A DST M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Sykesville, Maryland			
DATE SIGNED 6/21/56			
ACTUAL SIGNATURE Edmund Lusthaus M.D.			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 6/22/56			
22c. NAME OF CEMETERY OR CREMATORY Cathedral			
22d. LOCATION (City, town, or county) (State) St. Frederick, Md			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lohrey & Sons ADDRESS 1318 Hopkins			
24a. REC'D BY REGISTRAR DATE 6-22-56			
24b. REGISTRAR'S SIGNATURE C. Harry Jones			

BUREAU V. S.

JUN 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

A34
BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6951

CERTIFICATE OF DEATH

06041

Reg. Dist. No.

70

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Taneytown</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leila</u> Middle <u>Constance</u> Last <u>Reinamam</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/01</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Frock</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Raymond Bowers, Taneytown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Rectum</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>7 mons.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>56</u> , to <u>June 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>56</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. S. McVaugh</u> M.D.		ADDRESS (Street, city or town, state) <u>49 Frederick St. Taneytown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>		DATE SIGNED <u>6/9/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Margaret C. Kuss</u>		ADDRESS <u>Taneytown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>June 11/56</u>		24b. REGISTRAR'S SIGNATURE <u>Ethel M. Mehring</u>	

CERTIFICATE OF DEATH

1956

BUREAU V. 2

JUN 15 1956

RECEIVED

6952

CERTIFICATE OF DEATH

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodsboro, Md.	
c. LENGTH OF STAY IN 1b 3 wks.		d. STREET ADDRESS 11X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alexander Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle E. Last Renner		4. DATE OF DEATH Month June Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1875
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Long		14. MOTHER'S MAIDEN NAME Amanda Menges	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lamar Barrick		Address Woodsboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1956 to June 5, 1956 , that I last saw the deceased alive on June 5, 1956 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Messner M.D.		DATE SIGNED June 5, 1956	
PHYSICIAN'S NAME (Type) Dr. J. H. Messner		Union Bridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		22d. LOCATION (City, town, or county) (State) Rocky Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crespi		24a. REC'D BY REGISTRAR June 8, 1956	
ADDRESS Thurmont, Md.		24b. REGISTRAR'S SIGNATURE Leslie L. Repp	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: Karyland, Karyland

RESIDENCE: Woodstown, Md.

AGE: 3 mos.

DATE OF DEATH: March 27, 1932

CAUSE OF DEATH: White

PLACE OF DEATH: Frederick County

SEX: Male

DATE OF BIRTH: [illegible]

RECEIVED JUN 8 1932 BUREAU A. F. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film GL99 7-3-56 et

CERTIFICATE OF DEATH

06043

Reg. Dist. No. 74

6053

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 789 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle Raymond Last Richardson		4. DATE OF DEATH Month June Day 23 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Havre de Grace, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Richardson		14. MOTHER'S MAIDEN NAME Luvenia Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Alfred Raymond Richardson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced bilateral cavitory pulmonary TB 002X DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26 , 19 54 , to June 23 , 19 56 , that I last saw the deceased alive on June 23 , 19 56 , and that death occurred at 5.45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE T. F. Vestal M.D. Henryton, Md. PHYSICIAN'S NAME (Type) T. F. Vestal, M. D. Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/56	
22c. NAME OF CEMETERY OR CREMATORY St James		22d. LOCATION (City, town, or county) (State) Havre de Grace Md	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons		24a. REC'D BY REGISTRAR DATE 6-23-56	
ADDRESS Havre de Grace, Md		24b. REGISTRAR'S SIGNATURE Albert R. Swannham	

CERTIFICATE OF DEATH

DECEASED JAMES L. TAYLOR		SEX Male		AGE 78 1/2 years		RACE White	
BIRTH 1886		PLACE OF BIRTH Baltimore, Md.		RESIDENCE 112 West Street, Baltimore, Md.		OCCUPATION Retired	
DATE OF DEATH July 20, 1955		PLACE OF DEATH Home		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESSES (If known)		SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF REGISTRAR (If known)	
DATE OF SIGNATURE July 20, 1955		DATE OF SIGNATURE July 20, 1955		DATE OF SIGNATURE July 20, 1955		DATE OF SIGNATURE July 20, 1955	

RECEIVED
 JUN 28 1955
 BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06044

6054

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-03-2	
c. LENGTH OF STAY IN 1b <u>6Y 1M 9D</u>		d. STREET ADDRESS <u>14 Glenside Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>May</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Creager</u>		14. MOTHER'S MAIDEN NAME <u>Laura Ecker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Record, Springfield State Hospital</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, unresolved</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>903.7</u> (b) <u>Pyelonephritis</u> DUE TO (c) <u>Decubitus ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>weeks</u> <u>233ks</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip</u> <u>Chronic brain syndrome associated with senile brain disease, with psychosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Patient fell to floor in dayhall and suffered fracture 5/21/56</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4</u> 21 19 <u>56</u> p. m. <u> </u> <u> </u> <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>	20f. (City or town) (County) (State) <u>Sykesville Carroll Maryland</u>

21. I certify that I attended the deceased from <u>4/21/56</u> , to <u>6/5/56</u> , that I last saw the deceased alive on <u>6/5/56</u> , and that death occurred at <u>6:55A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u>	DATE SIGNED <u>6/5/56</u>
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-8-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rocky Ridge- Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son - Frederick - Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-11-56</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>

844-1173

1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06045

0055

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAE VIDLA SELBY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 4 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES WAGNER</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE HORTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>M.J. SELBY, NEW WINDSOR, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-vascular disease</u> <u>10 yrs</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>56</u> to <u>June 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>56</u> , and that death occurred at <u>5</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>M.E. Robertson</u> M.D. <u>New Windsor, Maryland</u> PHYSICIAN'S NAME (Type) <u>Merritt E. Robertson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WINTERS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEW WINDSOR RURAL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D.D. Hartzler & Sons, New Windsor, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>June 7</u>		24b. REGISTRAR'S SIGNATURE <u>Ernest S. Benschel</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. ADDRESS OF PHYSICIAN</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. NAME OF REGISTRAR</p> <p>23. ADDRESS OF REGISTRAR</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. NAME OF WITNESSES</p> <p>26. ADDRESS OF WITNESSES</p> <p>27. SIGNATURE OF WITNESSES</p> <p>28. NAME OF DECEASED</p> <p>29. ADDRESS OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>
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JUN 8 1956

RECEIVED

BUREAU V. B.

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE, MD.

02040

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. TIME OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>12. SIGNATURE OF REGISTRAR [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS [Illegible]</p>		<p>14. SIGNATURE OF WITNESS [Illegible]</p>	

BUREAU V. 1

JUN 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06047

6057

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Alegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>10 y 18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luke, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mabel K</u> Middle <u>Kirkpatrick</u> Last <u>Sively</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-1912</u>		9. AGE (In years lost birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles P. Sively</u>				14. MOTHER'S MAIDEN NAME <u>Effie Kirkpatrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>491X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Psychosis with convuls. disorder, epileptic deterioration							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1954</u> , to <u>June 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>56</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u> <u>6-29-56</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u> <u>Sykesville</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Plomer</u>		22d. LOCATION (City, town, or county) (State) <u>Allegheny Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Earl - Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>6/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. The text appears to be a medical or legal record, possibly a death certificate or a report of a disease. Some words like "diagnosis", "cause of death", and "date of death" are faintly discernible.]

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6058

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Hampstead</u>		d. STREET ADDRESS <u>Hampstead</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN - L - SLADE</u> First Middle Last		4. DATE OF DEATH <u>June 1</u> 19 <u>56</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 28 - 1923</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>assist to v. law.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black & Decker</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley M Slade</u>		14. MOTHER'S MAIDEN NAME <u>Emma Slade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-18-2954</u>	
17. INFORMANT <u>Beverly Hall Slade - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>201X Hodgkins Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>52</u> , to <u>June 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>6/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Beverly Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

COUNTY OF MARYLAND CITY OF BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE [Faint text]		TIME [Faint text]	

BUREAU V. 3

JUN 11 1956

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Handwritten signature

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

6959

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2Y 5M 27D</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
		d. STREET ADDRESS <u>3706 Hickory Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Prettman</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/68</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mose Smith</u>		14. MOTHER'S MAIDEN NAME <u>Louise Bowene</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Record, Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Edema of the lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Shock due to trauma</u> (c) <u>Lacerations of scalp and face.</u> <u>Fractures of nose, shoulder, ribs and fingers.</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs. +</u> <u>33 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with senile brain disease, psychotic</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Man was hit with scrub brush by another patient</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:15</u> <u>PM</u> <u>6/2/</u> <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Sykesville Carroll Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>6/4/56</u>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-7-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>	22d. LOCATION (City, town, or county) (State) <u>WOODLAWN</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chasometh Jr</u>		24a. REC'D BY REGISTRAR <u>6-5-56</u>	
ADDRESS <u>3677 Chasometh Ave</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weiss</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>FANNIE</u> First <u>CECELA</u> Middle <u>STITELY</u> Last		4. DATE OF DEATH <u>June</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27 - 1868</u> AGE (In years last birthday) <u>88</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Long</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Frank Stitley</u> Address <u>New Windsor, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gall bladder infection</u> 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-18-</u> , 19 <u>56</u> , to <u>6-19-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-19-</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. N. Regg</u>		ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>6-20-56</u>	
PHYSICIAN'S NAME (Type) <u>T H LEGG M D</u>		<u>UNION BRIDGE M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 22 - 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler & Sons, New Windsor Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>June 25/56</u>	24b. REGISTRAR'S SIGNATURE <u>Ernest S. Benedict</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06051

6061 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Carroll Co</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Carroll, Westminster</i>		LENGTH OF STAY (In this place) <i>3 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		TOWN <i>27</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Medview Convalescent Home</i>				STREET ADDRESS (If rural give location) <i>Westwoodland St.</i>			
3. NAME OF DECEASED (Type or Print) <i>JANET</i> (First) <i>STODDARD</i> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>JUNE 4 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Nov. 16, 1895</i>	9. AGE last birthday <i>60</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-wife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Woodland Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Walton</i>				14. MOTHER'S MAIDEN NAME <i>Hattie A. Drumbell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT & ADDRESS <i>Mrs. E. G. Bright, Remlap's Post Rt. #16, Silver Lake, N.H.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170X IMMEDIATE CAUSE (A) <i>Carcinomatosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Carcinoma Breast</i>						<i>11 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1950-19</i> to <i>June 4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>June 3</i> , 19 <i>56</i> , and that death occurred at <i>130</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>James G. Marsh</i>				M.D. <i>Westminster Md</i>		DATE SIGNED <i>6/4/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 8, 56</i>		NAME OF CEMETERY OR CREMATORY <i>Riverside Cemetery</i>		LOCATION (City, town, or county) (State) <i>Saugus, Mass.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Hurriet Miller</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Myers, Jr.</i>		ADDRESS <i>Westminster Md.</i>	
DATE <i>6-5-56</i>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CHURCH

15. SIGNATURE OF OTHER

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THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE RETURNED TO THE OFFICE OF RECORDS AND STATISTICS, 100 N. E. STREET, BALTIMORE, MARYLAND, UPON REQUEST.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06052

6962 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Westminster</u>		<u>3 yrs.</u>		TOWN <u>Rural Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Nettie</u>		(Middle) <u>M.</u>		(Last) <u>Weishaar</u>		(Month) <u>June</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>May 10, 1889</u>	<u>67</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel J. Flickinger</u>				<u>Amanda Pitzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Thomas J. Weishaar, Westminster, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Month</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Colon</u>						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1956</u> , to <u>June 14, 1956</u> , that I last saw the deceased alive on <u>June 10, 1956</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>James J. Marsh</u>				ADDRESS (Street, city, town, state) <u>Westminster Md</u>			
DATE <u>June 10, 1956</u>				DATE SIGNED <u>June 14, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 16, 1956</u>		<u>Baust Cemetery</u>		<u>Tyrone, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Harold Miller</u>		<u>Merwyn C. Foss</u>		<u>Taneytown, Maryland</u>	

BUREAU V. S.

JUN 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6663
CERTIFICATE OF DEATH

06053

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>17 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Wooley</u> Last <u>Wooley</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown (George B. Alexander)</u>				14. MOTHER'S MAIDEN NAME <u>Unknown (Nanny Lee Webster)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>(Alma S. Whipp) R #3 Hagerstown, Md.</u> <u>Springfield Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>322.1</u> (b) <u>Calculus in ureter</u> DUE TO (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 Chronic alcoholism with psychosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>50</u> , to <u>6/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>56</u> , and that death occurred at <u>5:00AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u> DATE SIGNED <u>6/7/56</u>							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>			M.D. <u>Sykesville, Maryland</u>			DATE SIGNED <u>6/7/56</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>			Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>				ADDRESS <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/12/56</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Waer</u>

C. Harry Waer
Sykesville, Md.

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BUREAU V. 31

1955

DEAD